HE 22.8/5: trans. 169

medicare
Home Health Agency Manual

Department of Health and Human Services
Health Care Financing Administration

7-5628 3

Transmittal No. 169 Date MAY 1985

REVISED MATERIAL	REVISED PAGE NOS.	REPLACED PAGES
Section 475	68.1 - 68.2 (2pp.)	68.1 - 68.2 (2pp.)
Section 475	----------	71.12 - 71.13 (2pp.)

CORRECTION - EFFECTIVE DATE. NOT APPLICABLE

Section 475, Completion of Form HCFA - 1450 For Home Health Agency Billing -Errors contained in HHA revision 165 have been corrected.

ORIGINAL

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Item 75. Employer Location
Where claiming a conditional payment under the circumstances described under items 69A, B, or C enter the specific location of the employer of the individual identified on the same line in item 71. A specific location is the city, plant, etc. in which the employer is located.

NOTE: Data elements 76-93 and "Intermediary Use Only" elements have been blocked out on the patient copy of the HCFA-1450.

Item 76. Principal and Other Diagnoses Descriptions
Not required.

Item 77. Principal Diagnosis Code
Report the principal diagnosis or diagnosis most related to the plan of treatment, according to the attending physician, in this item. Report the full ICD-9-CM diagnosis code, including all five digit codes where applicable.

Item 78-81. Other Diagnoses Codes
Enter the ICD-9-CM codes for up to four additional diagnoses for conditions co-existing according to the attending physician.

Item 82. Procedure Coding Method Used
Not required.

Item 83. Principal and Other Procedures Descriptions
Not required.

Item 84. Principal Procedure Code and Date
Not required.

Item 85 and 86. Other Procedure Codes and Dates
Not required.

Item 87. PSRO/UR Approval Stay Dates
Not required.

Item 88 and 89. PSRO/UR Approved Stay Dates
Not required.

Item 90. Number of Grace Days
Not required.

Item 91. Treatment Authorization Code
Not required.

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Item 92. Attending Physician I.D.
Not required.

Item 93. Other Physician I.D.
Not required.

Item 94. Remarks
Enter any remarks needed to provide information that is not shown elsewhere on the bill but which is necessary for proper payment.

When equipment has been sold to a beneficiary, enter "medical necessity (no.)months." This certifies that a physician's prescription indicates the required period of medical necessity for the equipment.

Provider Representatives Signature and Date
Make sure that the required physician's certification is in the records before signing the form. A stamped signature is acceptable.

Intermediary Use Only Area.
Not Required.

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